

8033

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City RFD 4</b>				c. LENGTH OF STAY IN 1b <b>RFD 4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 40</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM LEE CARTER</b>				4. DATE OF DEATH Month Day Year <b>July 19, 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-12-1874</b>	
9. AGE (In years last birthday) <b>84</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lemuel C. Carter</b>				14. MOTHER'S MAIDEN NAME <b>Alfreda Carson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Lottie Critzer, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic Cardio-Vascular Disease</b> (c) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1953</b> , to <b>July 19, 1958</b> , that I last saw the deceased alive on <b>July 18, 1958</b> , and that death occurred at <b>Ellicott City, Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ellicott City, Md. 7-19-58</b>							
ACTUAL SIGNATURE <b>William T. Garrison</b>				PHYSICIAN'S NAME (Type) <b>Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family</b>		22d. LOCATION (City, town, or county) (State) <b>Covington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Seabach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8034

## CERTIFICATE OF DEATH

08032

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alpha</b>		d. STREET ADDRESS <b>Alpha</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SEBASTIAN BROWN CISSEL Sr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Mdse</b>	
11. BIRTHPLACE (State or foreign country) <b>Highland, Md</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Wilbur F. Cissel</b>		14. MOTHER'S MAIDEN NAME <b>Clara Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>S. Brown Cissel, Marriottsville, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 6</b> , 19 <b>58</b> , to <b>July 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 12</b> , 19 <b>58</b> , and that death occurred at <b>1:30 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas J. Herbert</b> M.D.		ADDRESS (Street, city or town, state) <b>46 Church Rd</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>		DATE SIGNED <b>7/7/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-9-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Al. Higinbotham</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

8034

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

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8035

## CERTIFICATE OF DEATH

08033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 175</u>		d. STREET ADDRESS <u>Route 175</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Estelle Sims</u>		4. DATE OF DEATH <u>July 29 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Seneca, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sewell Clark</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. Oline Berninger, Jessup, Md</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypertensive Cardio</u> DUE TO (b) <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <u>                    </u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>	20f. (City or town) (County) (State) <u>                    </u>
21. I certify that I attended the deceased from <u>July 29, 1958</u> to <u>July 29, 1958</u> , that I last saw the deceased alive on <u>July 29, 1958</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK E SHIPLEY</u>		DATE SIGNED <u>7/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 31, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Friendship, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Conaldson</u>		ADDRESS <u>Laurel, Md</u>	
24a. REC'D BY REGISTRAR <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>AUG 5 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.  
FBI LAB. COMPL. 7-1-60

PLASTIC BOND

MADE IN U.S.A.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME (Last, first, middle) <i>JOHN J. BROWN</i>	
2. SEX <i>Male</i>	
3. AGE (in years and months) <i>45 - 00</i>	
4. DATE OF BIRTH <i>10-15-1914</i>	
5. PLACE OF BIRTH <i>Boston, Mass.</i>	
6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>	
8. DATE OF DEATH <i>11-10-1960</i>	
9. TIME OF DEATH <i>10:30 AM</i>	
10. PLACE OF DEATH <i>Home</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>	
12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. A. Smith</i>	
14. SIGNATURE OF REGISTRAR <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <del>XXXXXXXXXXXX</del> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harmans</b> <b>02x-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Universal Concrete Pipe Co.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEE</b> <b>XUMER</b> <b>FADOR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 2, 1922</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mike Fader (Dec)</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Unknown</b> <b>(Dec)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>War 11</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mike Fador- Harmans, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound Comminuted Skull Fracture</b> <b>9/2.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Block struck victim in head Boom on crane buckled while lifting large concrete pipe</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Block struck victim in head Boom on crane buckled while lifting large concrete pipe</b>	
20a. TIME OF INJURY Month <b>July</b> Day <b>21</b> Year <b>1958</b> Hour <b>5:20 PM</b> a. m.	20b. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>	20d. (City or town) (County) (State) <b>Jessups Howard Md</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Donald E. Fisher M.D.</b>		DATE SIGNED <b>7-21-58</b>	
EXAMINER'S NAME (Type) <b>Donald E. Fisher M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 24, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>River View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Apollo - Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. R. Singleton - Glen Burnie</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 25 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alf Leach</b>

For use by  
Physician

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - HARRISBURG, PA.  
8036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - HARRISBURG, PA.  
8036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of Birth: \_\_\_\_\_  
5. Place of Birth: \_\_\_\_\_  
6. Usual Residence: \_\_\_\_\_  
7. Date of Death: \_\_\_\_\_  
8. Time of Death: \_\_\_\_\_  
9. Cause of Death: \_\_\_\_\_  
10. Manner of Death: \_\_\_\_\_  
11. Signature of Examiner: \_\_\_\_\_  
12. Signature of Physician: \_\_\_\_\_  
13. Signature of Coroner: \_\_\_\_\_  
14. Signature of Juror: \_\_\_\_\_  
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85. Signature of Juror: \_\_\_\_\_  
86. Signature of Juror: \_\_\_\_\_  
87. Signature of Juror: \_\_\_\_\_  
88. Signature of Juror: \_\_\_\_\_  
89. Signature of Juror: \_\_\_\_\_  
90. Signature of Juror: \_\_\_\_\_  
91. Signature of Juror: \_\_\_\_\_  
92. Signature of Juror: \_\_\_\_\_  
93. Signature of Juror: \_\_\_\_\_  
94. Signature of Juror: \_\_\_\_\_  
95. Signature of Juror: \_\_\_\_\_  
96. Signature of Juror: \_\_\_\_\_  
97. Signature of Juror: \_\_\_\_\_  
98. Signature of Juror: \_\_\_\_\_  
99. Signature of Juror: \_\_\_\_\_  
100. Signature of Juror: \_\_\_\_\_



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup ( Rural )</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Jessup ( Rural )</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Rice</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1890</u>
9. AGE (In years less birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Emmie Conk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mrs. Annie Hickman</u>		Address <u>Jessup, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u>2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George E. Burgtorf</u> EXAMINER'S NAME (Type) <u>George E. Burgtorf</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>July 3, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Donaldson</u> ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Donaldson</u>		24c. REGISTRAR'S SIGNATURE <u>W. H. Donaldson</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08038  
8038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HOWARD CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>HOWARD CO.</b> COUNTY <b>MD.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>High Ridge Rd.</b>				d. STREET ADDRESS <b>High Ridge Rd</b>			
3. NAME OF DECEASED (Type or print) <b>MAURICE R. HOOPER</b>				4. DATE OF DEATH <b>7/2/58</b>		Day Year <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/900</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Seal Co</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>MAURICE R. HOOPER</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates at service) <b>None</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. MARGARET A. HOOPER</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> 24RS. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>George E. Burgtorf</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/3/58</b>	
EXAMINER'S NAME (Type) <b>GEORGE E. BURGTORF M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>7/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LODGEN PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac Nabbs &amp; Son</b>				ADDRESS <b>CATONSVILLE 28 MD</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

FOR STATE  
HEALTH DEPT.

11

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
2033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF BIRTH  
(Aged)

DECEASED

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DEATH REPORT

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>nr. Odenton rural</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>XXXXXX XXXXXXXXXX</i>				d. STREET ADDRESS <i>1 Bay 430, Hanover</i>			
3. NAME OF DECEASED (Type or print) <i>Loretta - Long</i>				4. DATE OF DEATH <i>July 27 1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>64 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Howard Co md</i>	
13. FATHER'S NAME <i>Charles L. Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Drenda Griffin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>XXXXXX</i>		17. INFORMANT <i>Thomas M Long</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Cardio Vascular (heart) disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X</i> <i>Diabetes</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1</i>			
20c. TIME OF INJURY Month <i>7</i> Day <i>19</i> Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>		20f. (City or town) <i>1</i> (County) <i>1</i> (State) <i>1</i>	
21. I certify that I attended the deceased from <i>7-26-58</i> to <i>7-27-58</i> and that death occurred at <i>12:4</i> M, from the causes and on the date stated above.				21. I lost saw the deceased alive on <i>7-26-58</i>			
ACTUAL SIGNATURE <i>Joseph Lipskey</i>				DATE SIGNED <i>7-30-58</i>			
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKY</i>				ADDRESS <i>1000 S. Mount Pleasant</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-30-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>West Liberty Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Howard County md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. O. Wilson</i>				24a. REC'D BY REGISTRAR <i>1000 S. Mount Pleasant</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

CERTIFICATE OF DEATH

2033

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Charlotte		27		F		W		Jan 27 1901		Home	
Cause of Death		Disease		Duration		Occupation		Signature of Physician		Signature of Registrar	
Cerebral Palsy		Cerebral Palsy		1 year		Housewife		J. W. [Signature]		[Signature]	
Place of Burial		Date of Burial		Name of Burial Place		Name of Minister		Name of Undertaker		Name of Witness	
Cemetery		Jan 28 1901		Cemetery		Rev. [Name]		[Name]		[Name]	
Name of Physician		Name of Registrar		Name of Minister		Name of Undertaker		Name of Witness		Name of Witness	
J. W. [Signature]		[Signature]		Rev. [Name]		[Name]		[Name]		[Name]	
Date of Death		Date of Burial		Name of Burial Place		Name of Minister		Name of Undertaker		Name of Witness	
Jan 27 1901		Jan 28 1901		Cemetery		Rev. [Name]		[Name]		[Name]	
Cause of Death		Disease		Duration		Occupation		Signature of Physician		Signature of Registrar	
Cerebral Palsy		Cerebral Palsy		1 year		Housewife		J. W. [Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8040

## CERTIFICATE OF DEATH

08038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kerger Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Kerger Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM GEORGE MARTIN</b> First Middle Last				4. DATE OF DEATH <b>July 11, 1958</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-3-1892</b> 9. AGE (In years last birthday) <b>66</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (State or foreign country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Martin</b>				14. MOTHER'S MAIDEN NAME <b>? Capstock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-07-3424</b>		17. INFORMANT <b>Mrs. Alice A. Martin, Ellicott City, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF URINARY BLADDER</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA, LIVER, LUNGS</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b> INTERVAL BETWEEN ONSET AND DEATH <b>27.</b> CHRONIC							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> :11 p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 APRIL</b> , 19 <b>54</b> to <b>11 JULY</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9 JULY</b> , 19 <b>58</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald E. Fisher M.D.</b>				ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b> DATE SIGNED <b>7-12-58</b>			
PHYSICIAN'S NAME (Type) <b>DONALD E. FISHER M.D. ELLICOTT CITY MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUL 15 58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Ellicott</b>	



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 8041 CERTIFICATE OF DEATH

08039

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Haward</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Haward</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laurel</i>		LENGTH OF STAY (in this place) <i>11 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Baltimore Blvd</i>				STREET ADDRESS (If rural give location) <i>Baltimore Blvd</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Living Jennings Perkins</i>				<b>4. DATE OF DEATH</b> (Month) <i>July</i> (Day) <i>6</i> (Year) <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>April 15 1895</i>	9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>19</i>		IF UNDER 24 HRS. Hours <i>58</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>218-05-5012</i>		17. INFORMANT & ADDRESS <i>Mrs Margaret Perkins, Laurel</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
434.1 IMMEDIATE CAUSE (A) <i>Pericardial Effusion</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Congestive Heart Failure</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 19 3P</i> , to <i>July 5 5P</i> , that I last saw the deceased alive on <i>July 5</i> , 19 <i>58</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert P. King</i>		M.D.		ADDRESS (Street, city, town, state) <i>3118 James Street, Md.</i>		DATE SIGNED <i>July 6, 1958</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 8 1958</i>		NAME OF CEMETERY OR CREMATORY <i>Lintheum Chapel</i>		LOCATION (City, town, or county) (State) <i>Clarksville Md.</i>	
24. REC'D BY REGISTRAR <i>W. L. Smith</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Smith</i>		ADDRESS <i>Laurel Md.</i>	
DATE <i>JUL 1 0 '58</i>							

# CERTIFICATE OF DEATH

FILE NO.

1. DEATH RECORD NO.

2. DATE

3. TIME

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. BIRTH DATE

12. BIRTH PLACE

13. MARITAL STATUS

14. PREVIOUS ILLNESS

15. PREVIOUS SURGERY

16. PREVIOUS TRAUMA

17. PREVIOUS DRUGS

18. PREVIOUS ALCOHOL

19. PREVIOUS TOBACCO

20. PREVIOUS OTHER

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DEPARTMENT OF HEALTH - BALTIMORE, MD

1. DEATH RECORD NO.

2. DATE

3. TIME

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. BIRTH DATE

12. BIRTH PLACE

13. MARITAL STATUS

14. PREVIOUS ILLNESS

15. PREVIOUS SURGERY

16. PREVIOUS TRAUMA

17. PREVIOUS DRUGS

18. PREVIOUS ALCOHOL

19. PREVIOUS TOBACCO

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DEPARTMENT OF HEALTH - BALTIMORE, MD

## 8042 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Sykesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Mary I Renehan</i> First Middle Last		4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1877</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Selby</i>		14. MOTHER'S MAIDEN NAME <i>Mary Grimes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>unk</i>	
17. INFORMANT <i>Mr Sydney Renehan - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of right parotid gland</i> <i>142.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>142.0</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1935</i> , 19 <i>7.7.58</i> , to <i>7.7.58</i> , 19 <i>7.7.58</i> , that I last saw the deceased alive on <i>7.7.58</i> , 19 <i>7.7.58</i> , and that death occurred at <i>12:01 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Liberty Road at Eldersburg</i> DATE SIGNED <i>7.7.58</i>			
ACTUAL SIGNATURE <i>H. Lawson</i>		M.D. <i>Liberty Road at Eldersburg</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Lawson, Jr., M.D.</i>		<i>Sykesville, P.O., Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-9-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>		ADDRESS <i>Sykesville, Md.</i>	24a. REC'D BY REGISTRAR <i>JUL 10 '58</i>
			24b. REGISTRAR'S SIGNATURE <i>W. Renehan</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

File No.

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of office

21. Signature of county

22. Signature of state

23. Signature of federal

24. Signature of international

25. Signature of universal

26. Signature of world

27. Signature of universe

28. Signature of everything

29. Signature of all

30. Signature of nothing

31. Signature of someone

32. Signature of no one

33. Signature of everybody

34. Signature of nobody

35. Signature of anyone

36. Signature of no one

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of office

21. Signature of county

22. Signature of state

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-JUVENILE



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8043

## CERTIFICATE OF DEATH

08041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>41 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give place of death) <u>Shaffers Convalescent Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>			
f. STREET ADDRESS <u>Route 175</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle <u>RUPPERT</u> Last				DATE OF DEATH <u>JULY</u> Month <u>25</u> Day <u>1958</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 14, 1899</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State as foreign country) <u>Richmond, Va.</u>	
13. FATHER'S NAME <u>Andrew Hedges (Wanskier)</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Duker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs Marie Beck Jessup, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma of Breast, Rt</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170X</u> DUE TO (c) <u>14H.</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 4 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-14</u> 19 <u>58</u> , to <u>7-25</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7-25</u> 19 <u>58</u> , and that death occurred at <u>7:15</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph M. Yosvico</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD #1 Jessup, Md.</u> DATE SIGNED <u>7-25-58</u>			
PHYSICIAN'S NAME (Type) <u>JOSE M. YOSVICO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 28, 1958</u>		<u>Meadowridge Memorial</u>		<u>Saney, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walt Connelley, Samuel, Md</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUL 30 '58</u>			



## CERTIFICATE OF DEATH

08042

Reg. Dist. No.

8044

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Jefferson</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Charles Town</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>TAYLOR MANOR HOSPITAL</b>				d. STREET ADDRESS <b>85 X 3</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>CARROLL</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 18, 1877</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Keyser W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Dennis Oliver Smith</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca Smith</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>175-07-0518</b>		17. INFORMANT Address <b>Mrs. Elmer Wageley, RFD Charles Town, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anteriosclerosis generalized, severe</b> DUE TO (c) <b>Senile psychosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 17, 19 58</b> to <b>July 31, 19 58</b> , that I last saw the deceased alive on <b>July 31, 19 58</b> , and that death occurred at <b>8:30 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Irving J. Taylor</b>				ADDRESS (Street, city or town, state) <b>Taylor Manor Hosp., Ellicott City, Md.</b>			
PHYSICIAN'S NAME (Type) <b>IRVING J. TAYLOR MD</b>				DATE SIGNED <b>7-31-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Charles Town W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8045 CERTIFICATE OF DEATH

08043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Blvd</u>		d. STREET ADDRESS <u>Washington Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Emile</u> First <u>Thys</u> Middle <u>Thys</u> Last		4. DATE OF DEATH <u>July</u> 11 1958	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1899</u>
9. AGE (In years, last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>moteler &amp; operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>motels</u>	
11. BIRTHPLACE (State or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frans Thys</u>		14. MOTHER'S MAIDEN NAME <u>Louise Van der Auvera</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>092-10-9149</u>	
17. INFORMANT <u>Jane Gavis Thys</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 34</u> , 1958, to <u>July 11</u> , 1958, that I last saw the deceased alive on <u>July 11, 1958</u> , and that death occurred at <u>445 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas R. Mazzocco</u> M.D.		ADDRESS (Street, city or town, state) <u>320 Montgomery, Laurel, Mo.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS R. MAZZOCCO</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 14, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Caldwell</u>		24a. REC'D BY REGISTRAR <u>W. W. Caldwell</u>	24b. REGISTRAR'S SIGNATURE <u>W. W. Caldwell</u>



